Examination of the Level of Patient Functioning in Relation to the Content and Frequency of Therapist Intervention

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Statement of the Research Problem

Interpretation is generally held to be the major curative factor in psychoanalysis, psychoanalytic psychotherapy, and short-term dynamic psychotherapy. (Freud, 1912; Strachey, 1934; Luborsky, 1984; Arlow, 1987). Described by Bibring (1954) as the "supreme agent in the hierarchy of therapeutic principles" (p. 763), interpretation is regarded as a central activity of the therapist, around which other aspects of treatment are organized to maximize its effectiveness. Despite the consensus of its clinical import, there is no universally accepted definition of an interpretation.

The concept of interpretation has evolved, as has its relationship to the therapeutic process. For Freud (1900, 1912, 1914), interpretation referred to the translation of the manifest into the latent content, whether this involved dreams, associations, symptoms, or behaviors of the neurotic patient. As the scope of psychoanalysis broadened to include patients with preoedipal and narcissistic pathology (referred to in this study as lower functioning), interpretation also acquired new dimensions. With lower functioning patients, the intent of interpretation shifted in relation to resistance, transference, and reconstruction. In a revised developmental and relational psychoanalytic framework, some authors (Ornstein and Ornstein, 1975; Pine, 1986a, 1986b, 1990) view interpretation primarily as a contact rather than a content or an insight promoting agent.

In sharp contrast to traditional psychoanalysis of higher functioning (primarily neurotic) patients, with lower functioning patients, the transference neurosis is avoided in favor of providing a "holding environment" (non-interpretive intervention) (Winnicott, 1965). Such therapy is typically more active and supportive, as well as less intense and interpretive. In actual practice, however, most clinicians are reported to use a mixture of interpretive (expressive) and holding (supportive) techniques early in treatment and throughout its course (Luborsky, 1984; Waldinger, 1987).

While clinicians have believed most strongly in the power of interpretation, they have provided little in the way of research data to support their convictions. There are very few solid

research studies on interpretation, and these studies have a range of aims, methods, and results. Studies of the role of interpretation in psychoanalysis, psychoanalytic psychotherapy, and brief dynamic psychotherapy have been in the following areas: (1) depth of interpretation (Dittman, 1952; Harway et al., 1955; Rausch et al., 1956. Speisman, 1959; Howe, 1962); (2) process studies of the immediate in-session responses of patients to interpretations (Garduk and Haggard, 1972; Luborsky, 1977); (3) outcome studies relating interpretation to treatment progress (Malan, 1976; Marziali and Sullivan, 1980; Marziali, 1984; Piper et al., 1986); and (4) accuracy of interpretation (Silberschatz et al., 1986; Crits-Christoph et al., 1988).

Of these studies, there are only a handful which consider the content of interpretation in short-term dynamic psychotherapy, the treatment method used in the present investigation (Malan, 1976; Marziali and Sullivan, 1980; Marziali, 1984; Piper et al., 1986). The major focus of these studies was relationship between treatment outcome and "object" interpretations. None examine the specific content and frequency of the therapist's interpretation in relation to the level of the patient's functioning. Therefore, this study addresses a significant theoretical and clinical assumption -- namely, that the therapist varies the specific content and frequency of his/her interpretations depending upon the level of patient functioning.

Research Questions

The therapist will modify the content and frequency of interpretation in relation to the level of patient functioning.

This major hypothesis leads to the following testable hypotheses:

(1) The therapist will make more interpretations (genetic, genetic transference, here-and-now transference, and extra-transference) with higher functioning patients than lower functioning ones.
(2) The therapist will be more verbally active (all remarks not categorized as interpretations) with lower functioning patients than higher functioning ones.
(3) The therapist will make more here-and-now transference interpretations than genetic transference interpretations with lower functioning patients.
(4) The therapist will make more extra-transference interpretations than transference (genetic or here-and-now) with lower functioning patients.
(5) The number of interpretations should increase from session three to session five for both higher and lower functioning patients.

Methodology

Utilizing a correlational design, this quantitative study examined the effect of the level of patient functioning (LPF) (independent variable) on the content and frequency of therapist interpretation (dependent variable). This study was part of a research grant provided by the National Institute of Mental Health to Paul Crits-Christoph, Ph.D., Director of the Penn Psychotherapy Research Center at the University of Pennsylvania and Principal Investigator on the grant. The grant was funded for the purpose of studying various aspects of the interpretive process. The definition of level of patient functioning developed for the present study will be employed in subsequent grant-supported studies on interpretation.

Patients -

The patient group consisted of 38 outpatients in short-term dynamic psychotherapy who met the criteria for a current episode of major depressive disorder as determined by their scores on the Schedule for Affective Disorders and Schizophrenia (SADS). The SADS was administered by a Ph.D. level psychologist-researcher. The patients ranged in age from 22 to 60, with a mean age of 37 (median = 37, S.D. = 9.6). Of the 38 patients, 29 (76%) were women and 9 (24%) were men; 12 (32%) of the patients were married while 26 (68%) were not married. In regard to education, all of the 38 patients had at least a high school degree, while 11 (28.9%) had some college, 15 (39.5%) had a college degree, and 9 (23.7%) had a graduate degree. In regard to race, 34 (89.5%) of the patients were white and 4 (10.5%) were black.

Treatment Characteristics -

All patients were seen in short-term individual psychotherapy for a period of sixteen weeks (one session per week). The therapists employed supportive-expressive-time-limited (SE-TL) treatment, an abbreviated version of psychoanalytic psychotherapy. SE-TL was originally developed at the Menninger Foundation and later revised by Lester Luborsky at the University of Pennsylvania, Penn Psychotherapy Research Center. SE-TL was particularly suited to this study, as it had applicability to a broad range of patients and its brief, finite treatment length enhanced its value for clinical research. With SE-TL, the therapist is expected to make an accurate decision within the first few sessions about the main relationship theme. This theme then becomes the focus of the therapeutic effort.

Therapists -

Four doctoral level mental health professionals (3 female, 1 male) participated in this research project. All four were experienced psychoanalytic psychotherapists who received ongoing group supervision from the senior researcher; two of them had previously participated in outcome and process studies of supportive-expressive psychotherapy. Each therapist treated several patients who were randomly assigned. The therapists were blind to the level of patient functioning (i.e., to patients' scores on the Health-Sickness Rating Scale). The therapists were not involved in the screening process.

Instruments -

The Health-Sickness Rating Scale (HSRS) is a clinician-rated measure of mental health

based on interviews. It is a highly reliable and widely used psychometric instrument. In this study, the HSRS was used as a general measure of psychiatric severity and level of patient functioning (LPF). HSRS ranges from 0 to 100; a score of 0 to 50 indicates lower functioning and a score of 51 to 100 indicates higher functioning. The scores ranged from 36 to 60, with a mean score of 50. Twenty-one patients were categorized as lower functioning, while 17 were categorized as higher functioning. There were no significant differences between higher and lower functioning patients in regard to age, race, gender, marital status or education. The Schedule for Affective Disorders and Schizophrenia (SADS) (Endicott and Spitzer, 1978) is a format for a highly structured diagnostic interview. The SADS involves a progression of questions, items, and criteria that systematically rule in or rule out specific Research Diagnostic Criteria (RDC). There are three versions of the SADS, but for the purposes of the present study, only the regular version was used.

Administration of Screening Instruments -

Each patient was given two initial pre-treatment screening batteries scheduled one week apart. At the first screening session, prospective patients were administered a Schedule for Affective Disorders and Schizophrenia (SADS) interview, from which the Health-Sickness Rating Scale (HSRS) data was gleaned. At the second screening session, the HSRS was rated again. The instruments were rated by a senior Ph.D. clinical psychologist trained in diagnostic interviewing at both assessments.

Identifying Interpretations -

One hundred twelve audiotaped sessions were transcribed and presented to three judges, all of whom were blind to LPF. Sessions numbered 3, 4, and 5 from 37 patients and session number 3 from 1 patient were used (sessions 4 and 5 were not audible for this latter patient). A therapist response scheme was developed to help judges clearly differentiate interpretations from other therapist responses. Interjudge agreement for differentiating interpretations from other comments was 93.5%. The average number of all interpretations per session for the 38 patients was 3.2.

Identifying Object and Temporal Aspects of Interpretation -

Statements which were already identified as interpretations were presented to three other judges, all of whom were blind to LPF. Reliability was calculated on the average number of each type of object (therapist, parents, significant others, self, siblings, none) and temporal (childhood, past, present, future) aspects per session. Based on the sample of 38 cases, the pooled interjudge reliability coefficients were .85 for therapist, .99 for parents, .95 for significant others, .76 for self, .36 for siblings, .87 for none, .74 for childhood, .84 for past, .98 for present, and .56 for future. The low interrater reliability for siblings (.36) and future (.56) is based on their low frequency in the sample.

Method of Data Analysis -

Age, gender, and marital status were used as control variables in a partial correlational analysis. Due to the restriction of variance, education and race were not used as control variables. Level of significance was set at $p = .05$, two-tailed test.

Results

The central hypothesis that the therapist would modify the content and frequency of interpretation based on the level of patient functioning was not supported. Therapists did not make more interpretations with higher functioning patients, nor did they exhibit a higher level of verbal activity with lower functioning patients. Therapists also did not make genetic transference interpretations with either group of patients. Additionally, the number of interpretations did not increase significantly from session 3 to session 5 for either higher or lower functioning patients.

The following findings were significant $p \leq .05$: (1) Therapists made more extra-transference than transference interpretations for both lower and higher functioning patients; (2) therapists were more verbally active with married patients than unmarried ones, regardless of level of patient functioning; and (3) therapists made more genetic interpretations with married patients than unmarried ones, regardless of level of patient functioning.

Due to the limited sample size, trends were considered in the .06 to .15 range. An expected finding was that therapists made more here-and-now transference interpretations with lower functioning patients than higher functioning ones ($p = .06$). Other findings which indicated statistical trends included the following: (1) The younger the patient, the more frequently the therapist made an interpretation, regardless of level of patient functioning; and (2) therapists were more verbally active with younger patients than older ones, regardless of level of patient functioning.

Utility for Social Work Practice

The findings of the study would seem to indicate that there are some discrepancies between theory and practice; that is, therapists do not always follow the recommendations in the literature, particularly in regard to the analysis of the transference. These findings have particular relevance to social work practitioners who traditionally have devoted themselves to the treatment of patients from all levels of functioning. With the current thrust toward short-term treatment in a managed care market, social work clinicians must adapt their techniques to meet these demands. This study raises an important question for the social work practitioner, which is whether interpretation is core to the treatment process. At present, one cannot make recommendations about clinical technique based upon this study's research results. Future research may eventually address the question of how therapists can vary their content and frequency of interpretation with different types of patients to provide positive treatment outcomes.

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